Your MEDICARE Handbook 1996

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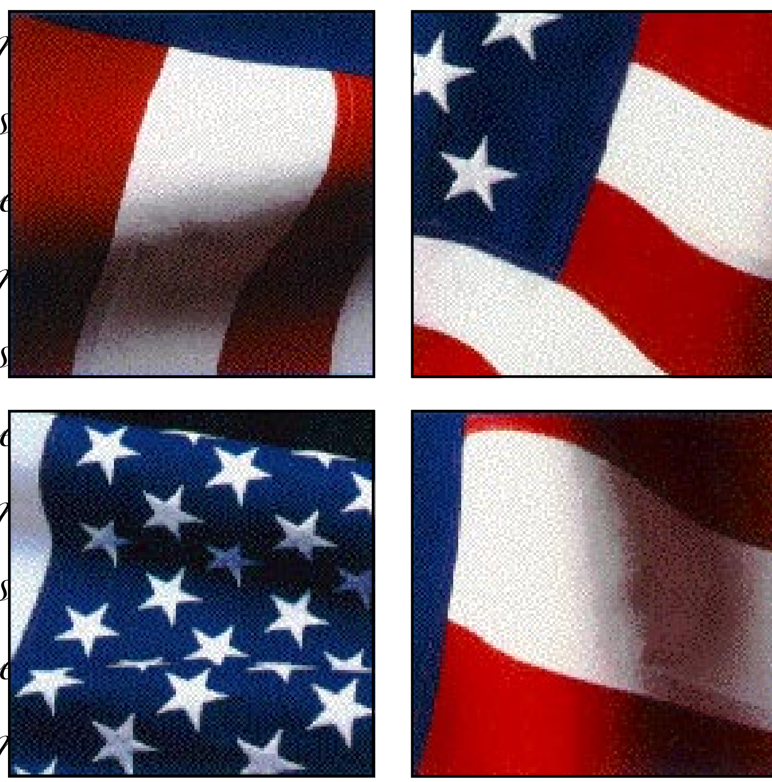

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HEALTH CARE FINANCING ADMINISTRATION

This handbook explains the Medicare program, but it is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

Message from the Secretary:

For three decades, Medicare has helped pay medical bills for millions of older Americans, providing them with comprehensive health benefits they can count on. Today, Medicare serves more than 38 million older and disabled Americans. Few programs, public or private, have such a positive impact on so many Americans.

Before the introduction of Medicare in 1966, only 50 percent of the Nation's elderly population had any health insurance. In 1996, 30 years later, only about 1 percent of the elderly are uninsured. Medicare has evolved into one of the world's best health insurance programs, delivering essential services that have improved the quality of life for many of our most vulnerable citizens.

We in the federal government, from President Clinton to the employees of the Department of Health and Human Services, are determined to continue to provide you with the first-rate health care and peace of mind which have always been Medicare's hallmark. If you are a new enrollee, we want to welcome you to Medicare. If you have been part of the Medicare beneficiary "family," we want to reassure you of our commitment to keep Medicare working for you.

Donna E. Shalala
Secretary, Department of Health and Human Services

Message from the Administrator:

It is with pride that the Health Care Financing Administration (HCFA) issues the 1996 edition of *Your Medicare Handbook* during this 30th anniversary year of the Medicare program.

This handbook was created to be a readable, easy to understand reference tool for Medicare beneficiaries. It provides information about benefits and answers the most frequently asked questions about Medicare. You'll find a summary of your Medicare benefits, rights and obligations, and a list of organizations that you can contact if you need assistance with a Medicare-related matter.

At HCFA, serving you is our top priority. That means providing you with world-class service and making sure that you have the information you need to best use your Medicare benefits. As the administrator of HCFA, the federal agency within the Department of Health and Human Services that administers Medicare, I can assure you that we take these commitments seriously. We're proud of Medicare's accomplishments, and want to be sure that you are satisfied with our service.

Bruce C. Vladeck
Administrator, Health Care Financing Administration

Introduction to Medicare

Your Medicare Handbook is intended to provide you with the information you need in order to take full advantage of your Medicare benefits. On the following pages you will learn about who's eligible for Medicare, how to enroll for Medicare and what hospital and medical expenses are covered by Medicare, and how much of the bill you are responsible for paying.

You will also find information about managed care plans and Medicare supplemental (Medigap) insurance. And in the back of the handbook you will find a glossary of Medicare terms and a directory that lists the names and telephone numbers of organizations that can help you with Medicare-related issues.

Medicare is administered by the Health Care Financing Administration (HCFA), a federal agency in the Department of Health and Human Services. The Social Security Administration (SSA) helps HCFA by enrolling people in Medicare and by collecting Medicare premiums. Various commercial insurance companies are under contract with HCFA to process and pay Medicare claims, and groups of doctors and other health care professionals have contracts to monitor the quality of care delivered to Medicare beneficiaries. And, of course, HCFA also forms partnerships with the thousands of providers of health care services — hospitals, nursing homes, and home health agencies; doctors; suppliers of medical equipment; clinical laboratories; and managed care plans such as health maintenance organizations (HMOs).

HCFA's goal is to provide you with quality services and publications. If after using *Your Medicare Handbook*, you would like to comment on the contents or design or offer suggestions for improving it, we would like to hear from you. We are particularly interested in knowing whether the handbook provides the information you need as a Medicare beneficiary, and whether it is easy to read and understand. Please send your comments to:

Health Care Financing Administration
Office of Beneficiary Relations
N-1005
7500 Security Boulevard
Baltimore, MD 21244-1850

This handbook is also available on audio tape for the visually impaired and on the Internet. HCFA's WEB site address is: **http://www.hcfa.gov**

Table of Contents

What is MEDICARE?

HEALTH INSURANCE

Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Both parts will be explained in more detail later, but basically Part A helps pay for care in a hospital and a skilled nursing facility, and for home health and hospice care. Part B helps pay doctor bills, and for outpatient hospital care and various other medical services not covered by Part A.

Who's Eligible for Medicare?

You are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment, and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with a chronic kidney disease.

Here are some simple guidelines. You can get Part A at age 65 without having to pay premiums if:

- ★ You are already receiving retirement benefits from Social Security or the Railroad Retirement Board.
- ★ You could receive Social Security or Railroad Retirement benefits but have not filed for them.
- ★ You or your spouse had Medicare-covered government employment.

If you are under 65, you can get Part A without having to pay premiums if:

- ★ You have received Social Security or Railroad Retirement Board disability benefits for 24 months.
- ★ You are a kidney dialysis or kidney transplant patient.

While you do not have to pay a premium for Part A if you meet one of those conditions, you must pay for Part B if you want it. The Part B monthly premium in 1996 is $42.50. It is deducted from your

Medigap Insurance

Worried about how you're going to pay your share of the bill for health care services covered by Medicare?

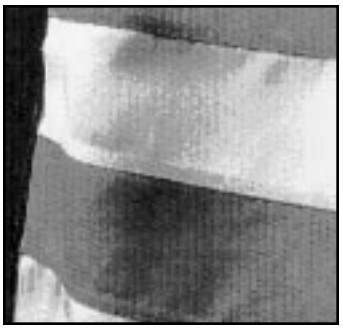
You may want to buy a Medicare supplemental insurance "Medigap" policy. Medigap is private insurance that is designed to help pay your Medicare cost-sharing amounts. There are 10 standard Medigap policies and each offers a different combination of benefits.

The best time to buy a policy is during your Medigap open enrollment period. For a period of six months from the date you are first enrolled in Medicare Part B and are age 65 or older, you have a right to buy the Medigap policy of your choice.

You cannot be turned down or charged higher premiums because of poor health if you buy a policy during this period. Once your Medigap open enrollment period ends, you may not be able to buy the policy of your choice. You may have to accept whatever Medigap policy an insurance company is

Social Security, Railroad Retirement, or Civil Service Retirement check.

If you have questions about your eligibility for Medicare Part A or Part B or if you want to apply for Medicare, call the Social Security Administration. The toll-free telephone number is: **1-800-772-1213.** You can also get information about buying Part A, as well as Part B, if you do not qualify for premium-free Part A. The Part A premiums for 1996 appear near the bottom of the chart on page 12.



willing to sell you. If you have Medicare Part B but are not yet 65, your six-month Medigap open enrollment period begins when you turn 65. In addition, a few states require a limited Medigap open enrollment period for Medicare beneficiaries under 65.

Your state insurance counseling office can answer questions about Medicare and other health insurance. The services are free. You can get help in deciding whether you need more insurance and, if so, what kind and how much to buy. A state-by-state listing of counseling office telephone numbers begins on page 22. Free copies of the Guide to Health Insurance for People with Medicare are also available from the counseling office.

*Suspected violations of the laws governing the marketing and sales of Medigap and other types of insurance policies should generally be reported to your state insurance department. If you believe you have been a victim of Medigap fraud, you can also call the federal toll-free number for registering such complaints. The number is **1-800-638-6833.***

Enrollment

Enrollment in Medicare is handled in two ways: either you are enrolled automatically or you have to apply. Here's how it works.

Automatic Enrollment: If you are already getting Social Security or Railroad Retirement benefits when you turn 65, you do not have to apply for Medicare. You are enrolled automatically in both Part A and Part B and your Medicare card is mailed to you about three months before your 65th birthday. If you do not want Part B, follow the instructions that come with the card.

If you are disabled, you will automatically get a Medicare card in the mail after you have received Social Security or Railroad Retirement Board disability benefits for 24 months.

Applying for Medicare: If you are not receiving Social Security or Railroad Retirement benefits three months before you turn 65, you need to apply for Medicare. You apply by contacting any Social Security Administration office or, if you or your spouse worked for the railroad, the Railroad Retirement Board.

Apply three months before you turn 65. That's the beginning of your seven-month initial enrollment period. By applying early you'll avoid a possible delay in the start of your Part B coverage.

If you do not enroll during this seven-month period, you'll have to wait to enroll during the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year and Part B coverage starts the following July.

Don't put off enrolling. If you wait 12 or more months to sign up, your premiums generally will be higher. **(Continued on page 5)**

Medicare and Managed Care

Managed care plans can represent good health care value. They provide all of Medicare's benefits and frequently more, and there is little or no paperwork.

You may have to pay a fixed monthly premium and a copayment each time a service is used. The premiums and copayments vary from plan to plan and can be changed each year. You also must continue to pay the Part B premium to Medicare. You do not pay Medicare's deductibles and coinsurance.

Usually there are no other charges no matter how many times you visit the doctor, are hospitalized, or use other covered services. Your costs are therefore more predictable than under fee-for-service Medicare.

In addition to offering you all your Medicare benefits, many plans promote preventive health care by providing extra benefits such as eye examinations, hearing aids, routine physicals, scheduled inoculations and prescription drugs for little or no extra fee.

Each plan has its own network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. Depending on how the plan is organized, services are usually provided either at one or more centrally located health facilities or in the private practice offices of the doctors and other health care professionals that are part of the plan. You generally must receive all covered care through the plan or from health care professionals to whom the plan refers you or else the plan will not pay.

Most managed care plans allow you to select a primary care doctor from those that are part of the plan. If you do not make a selection, one will be assigned to you. Your primary care doctor is responsible for managing your medical care, admitting you to a hospital and referring you to specialists. You are allowed to change your primary care doctor as long as you select another primary care doctor affiliated with the plan.

Types of Plans

Before enrolling in a managed care plan, find out whether the plan has a "risk" or a "cost" contract with Medicare. There's an important difference.

Risk Plans: These plans have "lock-in" requirements. This means that you generally are locked into receiving all covered care through the plan or ***(Continued on page 19)***

(Continued from page 3) Part B premiums go up 10 percent for each 12 months that you could have been enrolled but were not. The increase in the Part A premium (if you have to pay a premium) is 10 percent no matter how late you enroll for coverage.

Under certain circumstances, however, you can delay your Part B enrollment without having to pay higher premiums. If you are age 65 or over and have group health insurance based on your own or your spouse's current employment, or if you are disabled and have group health insurance based on your current employment or the current employment of any family member you have a choice:

★ You may enroll at any time while you are covered by the group health plan, or;

★ You can enroll during a special eight-month enrollment period that begins the month employment ends or the month you are no longer covered under the employer plan, whichever comes first.

If you do not enroll by the end of the eight-month period, you'll have to wait until the next general enrollment period, which begins January 1 of the next year.

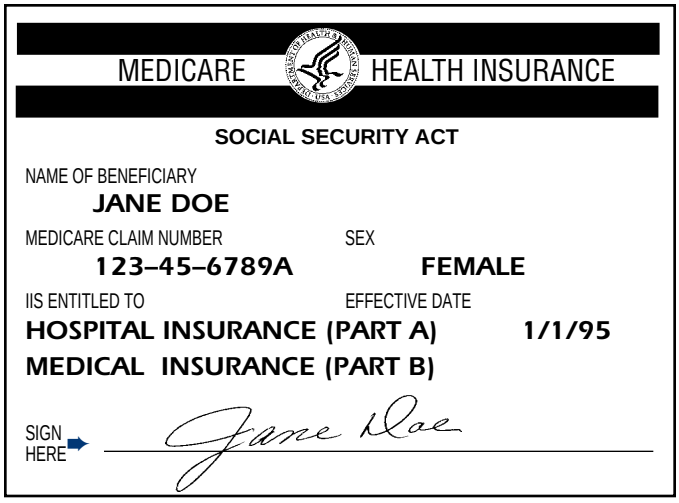
Even if you continue to work after you turn 65, you should at least sign up for Part A of Medicare. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B at the same time. You would have to pay the monthly Part B premium and the Part B benefits would be of limited value to you as long as the employer plan was the primary payer of your medical bills. Moreover, you would trigger your six- month Medigap open enrollment period (see Medigap Insurance, page 2).

Your Medicare Card

Once enrolled, you'll receive a Medicare card imprinted with your name and Medicare claim number. It shows what coverage you have (Part A, Part B or both) and the date your coverage started.

Show your card whenever you get medical care. This will assure that a claim for payment is sent to Medicare. Make sure to use your exact name and claim number. If you are married, your spouse will have his or her own card and claim number. Never let anyone else use your Medicare card, and keep the number as safe as you would a credit card number.

Take your card with you when you travel and have it handy when you call about a Medicare claim. If you lose your card, contact the Social Security Administration right away.


MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
123–45–6789A

SEX
FEMALE

IIS ENTITLED TO
HOSPITAL INSURANCE (PART A)
MEDICAL INSURANCE (PART B)

EFFECTIVE DATE
1/1/95

SIGN HERE

Fee-for-Service or Managed Care?

One important decision you may have to make is how you will receive your Medicare hospital and medical benefits. If you live in an area served by a managed care plan, you have a choice. You can receive your Medicare benefits either through the fee-for-

service system or through a managed care plan such as a health maintenance organization (HMO).

If you choose fee-for-service, you can go to almost any doctor, hospital or other health care provider you want to. Generally, a fee is charged each time a service is used. Medicare pays its share of the bill. You are responsible for paying the balance.

In managed care, you usually must get all of your care from the doctors, hospitals, and other health care providers that are part of the plan, except in emergencies. Depending on the plan, you may have to pay a monthly premium and a copayment each time you go to the doctor or use other services.

Regardless of whether you choose fee-for-service or managed care, you retain all of your Medicare benefits, protections and appeal rights.

Let's look at how the two systems work under Medicare. The following sections describe Medicare's Part A and Part B benefits and how Medicare works if you receive your health care through the fee-for-service system. The explanation of how Medicare works with managed care plans begins on page 4.

Who Pays First?

Medicare is not always the primary payer of your health care bills. Sometimes other insurers are required to pay before Medicare.

For example, Medicare is the secondary payer if you are entitled to workers' compensation or to federal black lung benefits for an illness or injury. Medicare also serves as the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer. And Medicare generally is the secondary payer for 18 months if you are a kidney dialysis patient covered by an employer group health plan.

Group health insurance is generally the primary payer if you are age 65 or older and have coverage based on your own or your spouse's current employment or if you are disabled and have group health insurance based on your current employment or the current employment of a family member. You can reject the employer's coverage. If you do, Medicare remains your primary payer and the employer's plan cannot offer you coverage that supplements Medicare-covered services.

If you have or can get both Medicare and veterans benefits, you may choose to get treatment under either program. But, Medicare:

Cannot pay for services you receive from Department of Veterans Affairs (VA) hospitals or other VA facilities, except for certain emergency hospital services, and;

Generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.

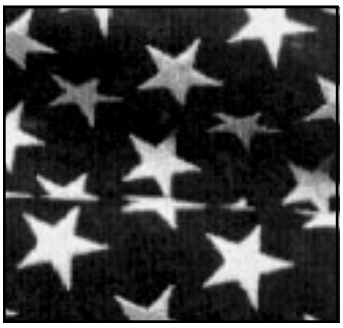
Hospitals, doctors, and other providers of health care services must submit Medicare claims for you. They need to know if you are covered by other insurance that is primary to Medicare before they submit any Medicare claims. If you have coverage that should pay before Medicare pays, you need to notify your doctor and other health care providers at the time services are provided.

MEDICARE *Part A Benefits*

MEDICARE COVERAGE

When all program requirements are met, Medicare Part A helps pay for:

★ Care in a hospital.



★ Care in a skilled nursing facility following a hospital stay.

★ Home health care.

★ Hospice care.

★ Blood, after the first three pints.

Benefit Periods

Coverage for care in hospitals and skilled nursing facilities is measured in "benefit periods." In each benefit period you are limited as to the number of days Medicare will help pay for inpatient hospital and skilled nursing facility care. Exceed the limit and you are responsible for all charges for each additional day of care.

A benefit period begins the day you are admitted to a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 straight days. It also ends if you are in a skilled nursing facility but have not received skilled care there for 60 straight days.

The next time you are admitted to a hospital, a new benefit period begins and your hospital and skilled nursing facility benefits are renewed. There is no limit to the number of benefit periods you can have.

Inpatient Hospital Care

If you need inpatient hospital care, Medicare Part A helps pay for up to 90 days of medically necessary care in a Medicare-certified hospital in a benefit period.

During the first 60 days Medicare pays all covered costs except for $736. That's the hospital deductible for 1996 and you are responsible for paying it. You only pay the deductible once during a benefit period no matter how many times you go to the hospital.

For the 61st through the 90th day in a benefit period, Medicare pays all covered costs except for coinsurance of $184 per day in 1996. You are responsible for paying the coinsurance.

Reserve Days: In the unlikely event that you are in the hospital for more than 90 days in a benefit period, you can use your "reserve days" to help pay the bill. When a reserve day is used Medicare pays all covered cost except for coinsurance of $368 in 1996. Again, you are responsible for paying the coinsurance.

You have a supply of 60 reserve days. Once a reserve day is used, it is not renewed. So if you use 10 reserve days, you'll have 50 left to use during the rest of your life.

Covered Hospital Services: When you are in the hospital, Part A helps pay for a semiprivate room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, laboratory tests and X-rays. Coverage is also provided for use of the operating and recovery rooms, intensive

care and coronary care units, and all other medically necessary services and supplies.

Hospital Services Not Covered: Medicare does not pay for personal convenience items such as a telephone or television in your room, for private duty nurses, or any extra charges for a private room unless it is medically necessary.

Qualifying for Hospital Care: Medicare helps pay for inpatient hospital care when these four requirements are met:

1. A doctor prescribes inpatient hospital care for an illness or injury.
2. Your illness or injury requires care that can only be provided in a hospital.
3. The hospital participates in Medicare.
4. The hospital's Utilization Review Committee or a Peer Review Organization (PRO) did not disapprove your stay.

Important Message: When you are admitted to the hospital for covered care, the hospital is required to give you a copy of a document called *An Important Message From Medicare*. If you don't get a copy be sure to ask for one.

The message explains your rights as a Medicare hospital patient. It also tells you what to do if you think you are being discharged from the hospital too early or are notified that Medicare will no longer pay for your hospital care.

Advance Directive: Hospitals also must tell you about your right to prepare an advance directive. An advance directive is a written statement that explains what services you want or do not want if you ever become unable to communicate your wishes during a medical emergency.

Involve loved ones and your legal and religious advisers in the preparation of your advance directive. They can help ensure that your wishes are followed should you become incapacitated. Your doctor also should be consulted and asked to include the advance directive in your medical records. An advanced directive is also called a "living will" or "durable power of attorney for health care."

Skilled nursing facilities, hospices, home health agencies and HMOs serving Medicare beneficiaries also must give you information about advance directives.

Psychiatric Hospital Coverage: In addition to covering care in a general hospital, Part A helps pay for care in a Medicare-participating psychiatric hospital. Coverage is limited to a lifetime maximum of 190 days of care. Psychiatric care provided in a general hospital is not subject to the 190-day limit. If you are a patient in a psychiatric hospital when you first become

Your Right to Appeal

If Medicare denies payment for health care services you received or pays less for those services than you think it should, you may have a right to appeal.

The specific steps you must take to start the appeal process vary depending on what kind of decision is being appealed. In all cases the notice you receive of a claim denial or other adverse action will include complete written instructions about how to appeal. For example, your appeal rights are detailed on the back of the Explanation of Medicare Benefits (EOMB) form that is mailed to you after you receive services covered by Part B of Medicare.

entitled to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Christian Science Sanatorium: Part A also helps pay for inpatient hospital and skilled nursing facility services provided by a participating Christian Science sanatorium. It must be operated or listed and certified by the First Church of Christ, Scientist, in Boston, to qualify for Medicare payment. Medicare will not pay for the practitioner.

Skilled Nursing Facility Care

If after being discharged from the hospital, you need to go to a skilled nursing facility, Medicare will help pay for your care for up to 100 days in a benefit period.

Part A pays the full cost of covered services for the first 20 days. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount of $92 in 1996. You are responsible for paying the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

What happens if you are discharged from a skilled nursing facility and later must be readmitted? If you are still in the same benefit period, Medicare will continue to help pay for your care until you have used up your 100 days of coverage. The care must be for a condition treated during your previous stay.

If you have been out of the skilled nursing facility 60 or more days and the benefit period has ended, another three-day hospital stay will be required before your skilled nursing facility care benefits are renewed.

A skilled nursing facility is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. The care must be either performed by or provided under the supervision of licensed nursing personnel.

Not all nursing homes are skilled nursing facilities. Most nursing homes primarily offer custodial care such as help in eating, bathing, taking medicine, and toileting. Medicare does not cover custodial care if that is the only care you need.

If you're in doubt about whether your stay in a skilled nursing facility will be covered by Medicare, ask your doctor or someone in the facility's business office. Keep in mind that a skilled nursing facility cannot require you to pay a cash deposit as a condition of admission unless it is clear that your care will not be covered by Medicare.

Under some circumstances you can get quick action on an appeal. For instance, if you believe you're being discharged too soon from the hospital, your appeal will receive immediate consideration and the hospital cannot discharge you before a decision is reached. There are various levels of appeal. Cases involving $1,000 or more can eventually be appealed up to a federal court.

More information about the appeal process may be obtained from a Medicare intermediary or carrier in your state. See the listing beginning on page 22. Some state insurance counseling programs will assist you through the appeal process. If you are enrolled in a managed care plan, contact the plan for information about your appeal rights.

Qualifying for Skilled Nursing Facility Care: Medicare pays for care in a skilled nursing facility when these five conditions are met:

1. You require daily skilled nursing or rehabilitation services that can only be provided in a skilled nursing facility.
2. You were in the hospital three days in a row, not counting the day of discharge, before entering the skilled nursing facility.
3. You are admitted to the facility within a short period of time (generally 30 days) after leaving the hospital.
4. The condition for which you are receiving skilled nursing care was treated in the hospital or arose while you were receiving care for a condition treated in the hospital.
5. A medical professional certifies that skilled nursing care is necessary.

Blood Coverage

You may need blood as part of a covered inpatient stay in a hospital or a skilled nursing facility—whole blood, units of packed red blood cells, or blood components. If so, Medicare will help pay the costs, including the cost of processing and administering it.

You must either pay for or replace the first three pints of blood each year—this is the annual blood deductible. You can replace the blood you use yourself or have another person donate on your behalf.

Both Part A and Part B of Medicare cover blood, and to the extent that you meet the three-pint blood deductible under one part you do not have to meet it under the other part.

Home Health Care

If you are confined to your home and require skilled care for an injury or illness, Medicare can pay for care provided in your home by a home health agency. A prior stay in the hospital is not required to qualify for home health care, and you do not have to pay a deductible for home health services.

Medicare Part A (or Part B if you do not have Part A) pays the entire bill for covered services for as long as they are medically reasonable and necessary. Coverage is provided for the services of skilled nurses, home health aides, medical social workers and different kinds of therapists. The services may be provided either on a part-time or intermittent basis, not full-time.

Besides paying for health care services, the home health benefit also covers the full cost of some medical supplies and 80 percent of the approved amount for durable medical equipment, such as wheelchairs, hospital beds, oxygen supplies and walkers.

Qualifying for Home Health Care: Medicare pays for home health care when these four conditions are met:

1. You require intermittent skilled nursing care, physical therapy, or speech language pathology.
2. You are confined to your home.
3. Your doctor determines that you need home health care and sets up a plan for you to receive care at home.
4. The home health agency providing the care participates in Medicare.

You can find a Medicare-approved home health agency by asking your doctor, your hospital discharge planner, or by looking in the Yellow Pages under “home health care.”

Hospice Care

Another benefit available under Part A is hospice care if you are terminally ill. You can elect to receive hospice care rather than regular Medicare benefits for the management of your illness.

Hospice care may be provided by either a private organization or a public agency for up to 210 days, or even longer in some cases. Emphasis is on providing comfort and relief from pain. While the Medicare hospice benefit primarily provides for care at home, it can help pay for inpatient care as well as for a variety of services not usually covered by Medicare, including homemaker services, counseling, and certain prescription drugs.

Medicare pays nearly the entire bill for hospice care. There can be a copayment of up to $5 for each drug prescription and about $5 per day for inpatient respite care. Respite care is intended to give temporary relief to the person or persons who regularly assist with home care.

Qualifying for Hospice Care: Medicare pays for hospice care when these three conditions are met:

1. Your doctor certifies that you are terminally ill.
2. You choose to receive hospice care instead of the standard Medicare benefits for the illness.
3. The care is provided by a Medicare-participating hospice program.

If you elect hospice care and later require treatment for a condition other than the terminal illness, you can use Medicare's standard benefits. When standard benefits are used, you must pay any required deductibles and coinsurance.

Part A Claims

When you receive services covered by Part A, you do not file a claim for payment. In fact, you seldom if ever have to get involved in the processing of a Part A claim.

The hospital, skilled nursing facility or other provider from whom you received services files the claim for you. It is sent to a private insurance organization called a "Medicare intermediary." The intermediary has a contract with the Federal Government to handle Part A claims.

The intermediary will send you a *Benefits Notice* showing what was billed, Medicare's portion of the bill, and what you are responsible for paying. All questions about charges and payments should be directed to the intermediary. The intermediary's address and telephone number appear on the notice.

Foreign Travel

Medicare, in general, will not pay for health care obtained outside the United States and its territories. There are some very limited exceptions for care obtained in Canada and Mexico. When in doubt about whether Medicare will pay for health care services, ask your Medicare carrier.

Kidney Disease Booklet

If you need more information about Medicare coverage of permanent kidney failure, you can get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services from any Social Security Administration office.

MEDICARE PART A: 1996

Services	Benefit	Medicare Pays	You Pay [1]
HOSPITALIZATION Semiprivate room and board, general nursing and other hospital services and supplies. (*Medicare payments based on benefit periods, see page 7).*	First 60 days	All but $736	$736
	61st to 90th day	All but $184 a day	$184 a day
	91st to 150th day[2]	All but $368 a day	$368 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies. *(Medicare payments based on benefit periods, see page 7)*	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $92 a day	Up to $92 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited costs for outpatient drugs and inpatient respite care.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.[3]

1996 Part A monthly premium: $289 with fewer than 30 quarters of Medicare-covered employment; $188 with more than 30 quarters but fewer than 40 quarters of covered employment. Most beneficiaries do not have to pay a premium for Part A.

[1] Either you or your insurance company are responsible for paying the amounts listed in the "You Pay" column.
[2] This 60-reserve-days benefit may be used only once in a lifetime *(see page 7).*
[3] Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

MEDICARE PART B: 1996

Services	Benefit	Medicare Pays	You Pay[1]
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible). Reduced to 50% for most outpatient mental health services.	$100 deductible, plus 20% of approved amount and limited charges above approved amount.
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital cost.	20% of whatever the hospital charges (after $100 deductible).
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).[2]
AMBULATORY SURGICAL SERVICES	Unlimited if medically necessary.	80% of pre-determined amount (after $100 deductible).	$100 deductible, plus 20% of pre-determined amount.

1996 Part B monthly premium: $42.50 (premium may be higher if you enroll late).

[1] Either you or your insurance company are responsible for paying the amounts in the "You Pay" column.

[2] Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid for or replaced under Part B.

MEDICARE *Part B Benefits*

MEDICARE COVERAGE

Medicare Part B picks up where Part A leaves off. It pays for a wide range of medical services and supplies, but perhaps most important, it helps pay doctor bills.

The medically necessary services of a doctor are covered no matter where you receive them—at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital.

Part B also helps pay for:

★ Outpatient hospital services.

★ X-rays and laboratory tests.

★ Ambulance transportation.

★ Breast prostheses following a mastectomy.

★ Services of certain specially qualified practitioners who are not doctors.

★ Physical and occupational therapy.

★ Speech language pathology services.

★ Home health care, if you do not have Part A of Medicare.

★ Blood, after the first three pints.

★ Flu, pneumonia and hepatitis B shots.

★ Pap smears for the detection of cervical cancer.

★ Mammograms to screen for breast cancer.

★ Outpatient mental health services.

★ Artificial limbs and eyes.

★ Arm, leg, back and neck braces.

★ Durable medical equipment, including wheelchairs, walkers, hospital beds and oxygen equipment prescribed by a doctor for home use.

★ Kidney dialysis and kidney transplants. Under limited circumstances, heart and liver transplants in a Medicare-approved facility.

★ Medical supplies and items such as ostomy bags, surgical dressings, splints and casts.

Benefit Limits

Some Part B benefits have special requirements and some are more strictly limited than others. Pap smears, for example, are generally covered once every three years, mammograms every 24 months, and therapeutic shoes once a year.

Durable Medical Equipment: Wheelchairs and other durable medical equipment are covered only when prescribed by a doctor for use at home and are provided by a supplier approved by Medicare. You can find out what equipment is covered and whether a supplier is approved by calling Medicare's durable medical equipment (DME) regional carrier for your area. A state-by-state listing of DME carriers begins on page 22.

Ambulance Services: The ambulance benefit is also strictly limited. Medicare will help pay for the service only if:

1. The ambulance, equipment and personnel meet Medicare requirements, and;

2. Transportation in any other vehicle could endanger your health.

Coverage is generally restricted to transportation between your home and a hospital, your home and a skilled nursing facility, or a hospital and a skilled nursing home.

What's Not Covered: Many medical services and items are not covered by Medicare. They include, but are not limited to, routine physicals, most dental care, dentures, routine foot care, hearing aids and most prescription drugs. Eyeglasses are only covered if you need corrective lenses after a cataract operation.

What You Pay

When you use your Part B benefits, you are responsible for paying the first $100 each year of the charges approved by Medicare. This is called the Part B annual deductible.

After the deductible is met, Medicare pays 80 percent of the Medicare-approved amount for most services. You are responsible for the remaining 20 percent. This is called coinsurance. Sometimes your share of the bill is more than 20 percent of the Medicare-approved amount. If you receive outpatient services at a hospital, you are responsible for paying 20 percent of whatever the hospital charges, not 20 percent of a Medicare-approved amount. If you receive outpatient mental health services, your share is 50 percent of the Medicare-approved amount.

Besides having to pay Medicare's deductibles and coinsurance, you are responsible for all charges for services and supplies you receive that are not covered by Medicare.

What Is Assignment?

Always ask your doctors and medical suppliers whether they accept assignment of Medicare. If they do, they will accept the amount Medicare approves for a particular service or supply and will not charge you more than the 20 percent coinsurance. That can mean savings for you.

Here's how. Let's suppose you go to a doctor who accepts assignment and that you have already paid the $100 Part B deductible for the year. Let's also assume that the Medicare-approved amount for the service you receive is $100.

Medicare would pay 80 percent of the $100 approved amount, or $80. You would be responsible for the other 20 percent, or $20. Medicare would pay its share of the bill directly to the doctor after the doctor filed your claim. The doctor could ask you to pay the $20 immediately but could not ask for more.

Here's what could happen if the doctor did not accept assignment. The doctor could charge $115, which is the $100 Medicare-approved amount plus the extra 15 percent that doctors who do not accept assignment are permitted to charge.

Medicare would pay 80 percent of $100, or $80 and you would be responsible for the remaining $35. But because Medicare pays its share of the bill to you and not the doctor when a claim is unassigned, the doctor could ask you to pay the $115 immediately. Medicare would send you a check for $80 after the doctor filed your claim.

Limiting Charge: Be aware that Federal law prohibits a doctor who does not accept assignment from charging more than 15 percent above Medicare's approved amount. Any overcharges must be refunded. In some states, the limit is even stricter.

Other Charge Limits: Doctors who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If you are not given a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount for the surgery performed.

Additionally, any doctor who does not participate in Medicare and who provides you with a service that he or she knows or has reason to believe Medicare will determine to be medically unnecessary, and thus will not pay for, must tell you that in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

To avoid excess charges go to doctors and medical suppliers who accept assignment. Some do on a case-by-case basis. Others sign agreements to accept assignment of all Medicare claims. They are called participating doctors and suppliers. You can get the names, addresses and telephone numbers of participating doctors and suppliers by calling your Medicare carrier.

Part B Claims

Carriers are private insurance companies that contract with the Federal Government to process Medicare claims and make payments for services and supplies covered by Part B.

Every time you go to the doctor for a service covered by Medicare, the doctor is required by law to send the claim for payment to the carrier for the area where the service was provided. After processing your claim, the carrier usually will send you a statement called an *Explanation of Medicare Benefits* (EOMB). It shows what was billed, the amount Medicare approved, and what you owe. It also tells you how to file an appeal if you disagree with a payment decision. Contact the carrier with any questions about a Part B claim. The carrier's name and telephone number are printed on the benefit notice. A state-by-state listing of Medicare carriers begins on page 22.

Fighting Medicare Fraud

Every year fraud costs Medicare $$$ and you pay part of those costs. You pay higher taxes and more in coinsurance and deductibles to cover these Medicare losses.

To help prevent Medicare from being ripped off, you should report all suspected instances of fraud and abuse.

Whenever you receive a payment notice from Medicare, review it for errors. The payment notice shows what Medicare was billed for, what Medicare paid and what you owe. Make sure Medicare was not billed for health care services or medical supplies and equipment that you did not receive.

If you suspect fraud, or have any questions about the bill, call the Medicare carrier or intermediary who sent you the payment notice. The carrier's or intermediary's

If you get Medicare under the Railroad Retirement system, your claims are processed by the MetraHealth office that serves your region. You can get the telephone number from any Railroad Retirement Board office.

Getting A Second Opinion

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

Medicare pays the same way for a second opinion as it pays for other doctor services as long as you are seeking advice for the treatment of a medical condition covered by Medicare. If the first two opinions contradict each other, Medicare will help pay for a third opinion.

You can ask your own doctor to refer you to another doctor for a second opinion. Or you can call your Medicare carrier and ask for the names and phone numbers of doctors in your area who provide second opinions.

name, address and telephone number appear on the notice.

Be suspicious that a provider may be attempting to defraud Medicare if any of the following things happen:

- ★ *You are offered free testing or screening in exchange for your Medicare number.*
- ★ *You are offered free medical equipment.*
- ★ *Some stranger claims to be from Medicare or another branch of the Federal Government and tries to sell you something.*
- ★ *A doctor or durable medical equipment supplier claims that you will not have to pay the 20 percent coinsurance or deductible that Medicare generally requires if you use his or her services. These charges can only be waived in special cases of financial hardship.*

Does Medicare Cover the Services of All Kinds of Medical Professionals?

Most of the doctor services covered by Medicare must be provided by either a doctor of medicine or a doctor of osteopathy. Under very limited circumstances, Medicare can help pay for the services of chiropractors, podiatrists, dentists, and optometrists.

As an example of how restrictive the coverage is, there is only one chiropractic service covered by Medicare. That's manipulation of the spine to correct a dislocation that can be shown by an X-ray. Medicare does not pay for an X-ray performed by a chiropractor.

When in doubt about whether a service is covered by Medicare call your Medicare carrier.

The carrier can also tell you whether Medicare will pay for services provided by a medical professional who is not a doctor. In some cases Medicare covers the services of certified registered nurse anesthetists, certified midwives, nurse practitioners, physician assistants, clinical social workers and clinical psychologists. The coverage is limited, so call your Medicare carrier to find out whether Medicare will pay for the kind of service you need.

Special Health Care Facilities

Besides helping to pay for care in a hospital or skilled nursing facility, Medicare covers a variety of services provided at special types of health care facilities.

Ambulatory Surgical Center: For example, Part B helps pay for certain types of surgery performed at a Medicare-approved ambulatory surgical center. This type of surgery does not require a hospital stay.

Rural Health Clinics: Various services provided at rural health clinics are also covered. These clinics serve areas where few people live. Medicare pays for services provided by the doctors, nurse practitioners, doctor assistants, nurse midwives, clinical psychologists and social workers that are part of the clinic.

Comprehensive Outpatient Rehabilitation Facility (CORF): Part B pays for services provided at a comprehensive outpatient rehabilitation facility if they were prescribed by a doctor and the facility participates in Medicare.

Community Mental Health Centers: Under certain conditions, Part B helps pay for outpatient mental health care provided by community mental health centers or hospital outpatient departments. These are specially qualified programs that provide partial hospitalization for mental health care. Check with the program you have chosen to see if it meets the conditions for Medicare payment.

Federally Qualified Health Centers: A full range of services can be obtained at federally qualified health centers. These facilities are mainly community health centers, Indian health clinics, migrant worker health centers and health centers for the homeless. They are generally located in inner-city and rural areas, and they are open to all Medicare beneficiaries.

Certified Medical Laboratory: Laboratory clinical diagnostic tests are covered when provided by a certified medical laboratory that participates in Medicare. The laboratory must accept assignment of your Medicare claim and cannot bill you. Part B pays all charges. (In Maryland only, you can be billed for 20 percent coinsurance for hospital outpatient tests.)

Programs That Help Low-Income Beneficiaries

If you are a Medicare beneficiary with a very low-income and few assets, you might qualify for state assistance in paying your health care costs. There are two programs that can help.

One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program.

The QMB program pays Medicare's premiums, deductibles and coinsurance for certain elderly and disabled persons who are entitled to Medicare Part A. Your income must be at or below the national poverty level and your savings and other assets cannot exceed $4,000 for one person or $6,000 for a couple.

The monthly income limits for the QMB program in 1996 for all states except Alaska and Hawaii are $665 for an individual and $884 for a couple. In Alaska the monthly income limits are $825 for an individual and $1,099 for a couple while in Hawaii they are $763 for an individual and $1,014 for a couple.

The SLMB program is for persons entitled to Medicare Part A whose incomes are slightly higher than the national poverty level. The program pays only your Medicare Part B premium. The monthly income limits for the SLMB program in 1996 for all states except Alaska and Hawaii are $794 for an individual and $1,056 for a couple.

In Alaska the monthly income limits are $986 for an individual and $1,314 for a couple while in Hawaii they are $912 for an individual and $1,213 for a couple.

For more information contact your state or local Medicaid, public welfare or social services office. You can find the number in the telephone directory under "State Government."

Be Prevention Smart

Medicare helps pay for flu shots, and it is recommended that you consider getting a flu shot in the fall each year, before flu season. And if you have not had a pneumonia shot, you may want to get one when you get your flu shot. One pneumonia shot may protect you for a lifetime. It must be ordered by your doctor.

Medicare helps pay for X-ray screenings for the detection of breast cancer and for Pap smears to detect cervical cancer. Women 65 or older can use the breast screening benefit every 24 months, while some younger women covered by Medicare can use it more frequently. Pap smears are covered every three years, except for certain women at high risk who can get one more frequently.

Medicare also helps pay for the hepatitis B vaccine if you are at high or intermediate risk of contracting hepatitis B. The shot must be ordered by your doctor.

Managed Care

(Continued from page 4)

through referrals by the plan. In most cases, if you receive services that are not authorized by the plan, neither the plan nor Medicare will pay.

The only exceptions recognized by all Medicare-contracting plans are for emergency services, which you may receive anywhere in the United States, and for services you urgently need when you are temporarily out of the plan's service area.

A third exception offered by a few risk plans is called the "point-of-service" (POS) option. Under the POS option, the plan permits you to receive certain services outside the plan's provider network and the plan will pay a percentage of the charges. In return for this flexibility expect to pay at least 20 percent of the bill.

Cost Plans: These plans do not have lock-in requirements. If you enroll in a cost plan, you can either go to health care providers affiliated with the plan or go outside the plan. If you go outside the plan, the plan probably will not pay but Medicare will.

Medicare will pay its share of charges it approves. You will be responsible for Medicare's coinsurance, deductibles and other charges, just as if you were receiving care under the fee-for-service system.

Because of this flexibility, a cost plan may be a good choice for you if you travel frequently, live in another state part of the year, or want to use a doctor who is not affiliated with a plan.

Enrolling in a Plan

Most Medicare beneficiaries can enroll in a managed care plan. To enroll:

1. You must have Medicare Part B and continue paying Part B premiums.
2. You must live in the plan's service area.
3. You cannot be receiving care in a Medicare-certified hospice.
4. You cannot have permanent kidney failure at the time of enrollment.

The names of the plans in your area are available by calling your state insurance counseling office. (See state-by-state listing beginning on page 22.) Insurance counselors will give you information about the plans in your state to help you decide whether managed care is right for you.

All plans that have contracts with Medicare must have an advertised open enrollment period of at least 30 days once a year. Plans must enroll Medicare beneficiaries in the order of application. You cannot be rejected because of poor health.

If your area is served by more than one plan, compare the doctors' qualifications, facilities, premiums, copayments, and benefits to determine which plan best suits your needs at a price you can afford. Determine whether the plan's providers are in a location convenient to you and whether transportation is available at all hours to get you to them.

Carefully weigh the advantages and disadvantages of plan membership if you travel a lot or live part of the year in another state. Plans must provide coverage for a fixed period of time when you travel.

Also keep in mind that if you enroll in a plan and later move out of the plan's service area, you will have to disenroll and either return to fee-for-service Medicare or enroll in a plan that serves your new location. Because each plan is different, your benefits and premiums probably will not be exactly the same if you enroll in another plan.

Leaving A Plan

You can stay in a managed care plan as long as it has a Medicare contract or you can leave at any time to join another plan or to return to fee-for-service Medicare.

To end your enrollment, send a signed request to the plan or to your local Social Security Administration office or, if appropriate, the Railroad Retirement Board. You return to fee-for-service Medicare the first day of the next month after the plan receives your request to disenroll.

To change from one managed care plan to another, simply enroll in the other plan as long as it has a Medicare contract. You are automatically disenrolled from the first plan.

Medigap insurance is another issue that you should consider if you are thinking about enrolling in a plan or if you are already in a plan and are thinking about disenrolling.

If you have a Medigap policy and decide to enroll in a plan, you may either keep the policy or, if after deciding you like the plan, you may cancel it. You generally do not need a Medigap policy if you are in a managed care plan.

A Medigap policy could be of value to you if you leave the plan and return to fee-for-service Medicare. If you previously had a Medigap policy but dropped it while in the plan or never had one before you joined the plan, you might not be able to buy the policy of your choice, especially if you have a health problem.

Medicare Beneficiary Resource Directory

This directory provides a state-by-state listing of Medicare carriers, Peer Review Organizations (PROs), Medicare durable medical equipment regional carriers and state insurance counseling offices. The telephone numbers for the Health Care Financing Administration's 10 regional offices are also provided. An explanation of the assistance available from each of these organizations follows.

MEDICARE CARRIERS can answer questions about Medicare coverage and Medicare Part B claims. The toll-free 800 numbers listed, in many cases, can be used only in the states where the carriers are located. Out-of-state callers may use a carrier's commercial number, if one is listed.

PEER REVIEW ORGANIZATIONS (PROs) are groups of practicing doctors and other health care professionals paid by the Federal Government to monitor the quality of care provided to Medicare patients by hospitals, skilled nursing facilities, home health agencies, managed care plans and ambulatory surgical centers. If the quality of care you received from one of these facilities was unsatisfactory, you may file a written complaint with the PRO. If you need help in preparing the complaint, the PRO will take the information from you over the telephone and write the complaint for you.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS can tell you what durable medical equipment (wheelchairs, hospital beds, etc.) is covered by Medicare and what the Medicare-approved amount is for a particular piece of equipment. The regional carrier can also identify durable medical equipment suppliers in your area who are approved by Medicare. If you have a complaint about a supplier or suspect that you have been improperly billed for durable medical equipment or otherwise defrauded, contact your durable medical equipment regional carrier.

STATE INSURANCE COUNSELING AND ASSISTANCE PROGRAM offices can provide you with general information about Medicare, Medicaid, managed care plans and the various types of health insurance available to supplement Medicare, including Medigap and long-term care insurance. Counselors can also help you with questions about your medical bills, insurance claims and Medicare benefit explanation forms. The services are free.

THE SOCIAL SECURITY ADMINISTRATION can answer questions about Medicare enrollment, entitlement and premiums, and help you replace a lost Medicare card. Call **1-800-772-1213.**

HEALTH CARE FINANCING ADMINISTRATION REGIONAL OFFICES can answer questions about Medicare policy and help resolve Medicare-related problems involving a Medicare carrier, PRO or other organization that is under contract to the Federal Government to serve Medicare beneficiaries. These offices can also give you the names of managed care plans that serve your area. For general information about Medicare or for help with a specific issue, you should first contact the organization listed above that provides the services you need or handles the type of issues or problems that you want help with. If you still are not satisfied, call the HCFA regional office that serves your state. The service areas and telephone numbers appear on page 29.

INSURANCE COUNSELING GENERAL INFORMATION	MEDICARE CARRIERS	PEER REVIEW ORGANIZATIONS (PROs)	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS
ALABAMA			
1-800-243-5463	Blue Cross/Blue Shield of Alabama 1-800-292-8855 or 205-988-2244	Alabama Quality Assurance Foundation 1-800-760-3540	Palmetto Government Benefits Administrators 1-800-213-5452 (Spanish @ 1-800-213-5446)
ALASKA			
1-800-478-6065 907-562-7249	Aetna Life Insurance Co. 1-800-452-0125 or 503-222-6831	PRO-WEST 1-800-445-6941	CIGNA Medicare 1-800-899-7095
ARIZONA			
1-800-432-4040 602-542-6595	Aetna Life Insurance Co. 1-800-352-0411 or 602-861-1968	Health Services Advisory Group, Inc. 1-800-359-9909	CIGNA Medicare 1-800-899-7095
ARKANSAS			
1-800-852-5494 501-371-2780	Blue Cross/Blue Shield 1-800-482-5525 or 501-378-2320	Arkansas Foundation for Medical Care, Inc. 1-800-824-7586	Palmetto Government Benefits Administrators 1-800-213-5452
CALIFORNIA			
1-800-434-0222 916-323-7315	Transamerica Occidental Life Ins. Co. Counties of Los Angeles, Orange, San Diego,Ventura, Imperial, San Luis Obispo, and Santa Barbara 1-800-675-2266 or 213-748-2311 Rest of State: Blue Shield of California 1-800-952-8627 or 916-743-1583	California Medical Review, Inc. 1-800-841-1602 or *415-882-5800	CIGNA Medicare 1-800-899-7095
COLORADO			
1-800-544-9181 303-894-7499 ext. 356	Blue Shield of North Dakota 1-800-332-6681 or 303-831-2661	Colorado Foundation for Medical Care 1-800-727-7086 or 303-695-3333	Palmetto Government Benefits Administrators 1-800-213-5452
CONNECTICUT			
1-800-994-9422	MetraHealth 1-800-982-6819 or 203-728-6783 Meridan 203-237-8592	Connecticut Peer Review Organization, Inc. 1-800-553-7590 or 203-632-2008	MetraHealth 1-800-842-2052

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INSURANCE COUNSELING GENERAL INFORMATION	MEDICARE CARRIERS	PEER REVIEW ORGANIZATIONS (PROs)	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS
DELAWARE			
1-800-336-9500	Xact Medicare Services 1-800-851-3535	Health Care Excel 1-800-642-8686 ext 266	MetraHealth 1-800-842-2052
DISTRICT OF COLUMBIA			
202-676-3900	Xact Medicare Services 1-800-233-1124	Delmarva Foundation for Medical Care, Inc. 1-800-645-0011 D.C. / 1-800-492-5811 MD.	AdminaStar Federal Inc. 1-800-270-2313
FLORIDA			
1-800-963-5337	Blue Cross/ Blue Shield of FLA. Copies of Benefits notices, requests for MEDPARD directories, address changes and brief claims inquiries (status or verification of receipt) 800-666-7586 or 904-355-8899 For all your other Medicare needs: 800-333-7586 or 904-355-3680	Florida Medical Quality Assurance, Inc. 1-800-844-0795 or 813-281-9024	Palmetto Government Benefits Administrators 1-800-213-5452
GEORGIA			
1-800-669-8387	Aetna Life Insurance Company 1-800-727-0827 or 912-920-2412	Georgia Medical Care Foundation 1-800-982-0411 or 404-982-0411	Palmetto Government Benefits Administrators 1-800-213-5452
HAWAII			
808-586-0100	Aetna Life Insurance Company 1-800-272-5242 or 808-524-1240	Hawaii Medical Service Association	CIGNA Medicare 1-800-899-7095
IDAHO			
S.W. 1-800-247-4422 1-800-488-5725	CIGNA Medicare 1-800-627-2782 or 208-342-7763	PRO-WEST 1-800-445-6941 or 208-343-4617	CIGNA Medicare 1-800-899-7095
ILLINOIS			
1-800-548-9034	Claims/Health Care Service Corp. 1-800-642-6930 or 312-938-8000 TDD 1-800-535-6152	Crescent Counties Foundation for Medical Care 1-800-647-8089 or 708-769-9600	AdminaStar Federal Inc. 1-800-270-2313
INDIANA			
1-800-452-4800	AdminaStar Federal 1-800-622-4792 or 317-842-4151	Indiana Medical Review Organization 1-800-288-1499	AdminaStar Federal Inc. 1-800-270-2313

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INSURANCE COUNSELING GENERAL INFORMATION	MEDICARE CARRIERS	PEER REVIEW ORGANIZATIONS (PROs)	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS
IOWA			
1-800-351-4664	IASD Health Services Corporation Blue Cross & Blue Shield of Iowa 1-800-532-1285 or 515-245-4785	Iowa Foundation for Medical Care 1-800-752-7014 or 515-223-2900	CIGNA Medicare 1-800-899-7095
KANSAS			
1-800-432-3535	Blue Cross/Blue Shield of Kansas Counties of: Johnson and Wyandotte 1-800-892-5900 or 816-561-0900 Rest of state: 1-800-432-3531or 913-232-3773	The Kansas Foundation for Medical Care 1-800-432-0407 or 913-273-2552	CIGNA Medicare 1-800-899-7095
KENTUCKY			
1-800-372-2973 502-564-7372	AdminaStar of Kentucky 1-800-999-7608 or 502-425-6759	Kentucky Medical Review Organization 1-800-288-1499	Palmetto Government Benefits Administrators 1-800-213-5452
LOUISIANA			
1-800-259-5301 504-342-0828	Blue Cross & Blue Shield, Inc. 1-800-462-9666 or 504-529-1494 Baton Rouge: 504-927-3490	Louisiana Health Care Review, Inc. 1-800-433-4958 or 504-926-6353	Palmetto Government Benefits Administrators 1-800-213-5452
MAINE			
1-800-750-5353	C and S Administrative Services 1-800-492-0919 or 207-828-4300 Outside of Maine 207-945-0244	Health Care Review, Inc. 1-800-541-9888 or 1-800-528-0700	MetraHealth 1-800-842-2052
MARYLAND			
1-800-243-3425 410-225-1074	Xact Medicare Services Counties of: Montgomery & Prince George's 1-800-233-1124/Other areas Trail Blazer Enterprises 1-800-492-4795	Delmarva Foundation for Medical Care 1-800-492-5811 Outside Maryland 1-800-645-0011	AdminaStar Federal Inc. 1-800-270-2313
MASSACHUSETTS			
1-800-882-2003 617-727-7750	C and S Administrative Services 1-800-882-1228 or 617-741-3300	Massachusetts Peer Review Organization 1-800-252-5533 or 617-890-0011	MetraHealth 1-800-842-2052
MICHIGAN			
1-800-803-7174	Michigan Medicare Claims 1-800-482-4045 or 313-225-8200	Michigan Peer Review Organization 1-800-365-5899	AdminaStar Federal Inc. 1-800-270-2313

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INSURANCE COUNSELING GENERAL INFORMATION	MEDICARE CARRIERS	PEER REVIEW ORGANIZATIONS (PROs)	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS
MINNESOTA			
1-800-882-6262	MetraHealth 1-800-352-2762 or 612-884-7171	Foundation for Health Care Evaluation 1-800-444-3423	AdminaStar Federal Inc. 1-800-270-2313
MISSISSIPPI			
1-800-948-3090	MetraHealth 1-800-682-5417 or 601-956-0372	Mississippi Foundation for Medical Care 1-800-844-0600 or 601-948-8894	Palmetto Government Benefits Administrators 1-800-213-5452
MISSOURI			
1-800-390-3330	Blue Cross/Blue Shield of Kansas Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Claire, Saline, Vernon and Worth 1-800-892-5900 or 816-561-0900 Rest of state: Medicare General American Life Insurance Company 1-800-392-3070 or 314-843-8880	Missouri Patient Care Review Foundation 1-800-347-1016	CIGNA Medicare 1-800-899-7095
MONTANA			
1-800-332-2272	Blue Cross/Blue Shield of Montana 1-800-332-6146 or 406-444-8350	Montana-Wyoming Foundation Medical Care 1-800-497-8232 or 406-443-4020	CIGNA Medicare 1-800-899-7095
NEBRASKA			
402-471-2201	Blue Cross /Blue Shield of Kansas 1-800-633-1113	Iowa Foundation For Medical Care 1-800-247-3004 or 1-800-422-4812	CIGNA Medicare 1-800-899-7095
NEVADA			
1-800-307-4444 702-367-1218	Aetna Life Insurance Company 1-800-528-0311 or 602-861-1968	HealthInsight 1-800-748-6773 or *702-385-9933	CIGNA Medicare 1-800-899-7095

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INSURANCE COUNSELING GENERAL INFORMATION	MEDICARE CARRIERS	PEER REVIEW ORGANIZATIONS (PROs)	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS
NEW HAMPSHIRE			
1-800-852-3388 603-271-4642	C and S Administrative Services 1-800-447-1142 or 207-828-4300	Northeast Health Care Quality Foundation 1-800-772-0151or 603-749-1641	MetraHealth 1-800-842-2052
NEW JERSEY			
1-800-792-8820	Xact Medicare Services 1-800-462-9306	The PRO of New Jersey Inc. 1-800-624-4557 or *908-238-5570	MetraHealth 1-800-842-2052
NEW MEXICO			
1-800-432-2080	Aetna Life Insurance Company 1-800-423-2925 or 505-821-3350	New Mexico Medical Review Association 1-800-279-6824 or 505-842-6236	Palmetto Government Benefits Administrators 1-800-213-5452
NEW YORK			
1-800-333-4114 In New York City: 212-869-3850	Empire Blue Cross and Blue Shield Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster & Westchester 1-800-442-8430 or 516-244-5100 Queens County: 212-721-1770 Rest of state: BC/BS of Western N.Y. 1-800-252-6550	Island Peer Review Organization, Inc. 1-800-331-7767 or *516-326-7767	MetraHealth 1-800-842-2052
NORTH CAROLINA			
1-800-443-9354	CIGNA 1-800-672-3071 or 919-665-0341	Medical Review of North Carolina 1-800-722-0468 or 919-851-2955	Palmetto Government Benefits Administrators 1-800-213-5452
NORTH DAKOTA			
1-800-247-0560	Blue Shield of North Dakota 1-800-247-2267 or 701-277-2363	North Dakota Health Care Review, Inc. 1-800-472-2902 or *701-852-4231	CIGNA Medicare 1-800-899-7095
OHIO			
1-800-686-1578	Nationwide Mutual Insurance Co. 1-800-282-0530 or 614-249-7157	Peer Review Systems, Inc. 1-800-837-0664 or 1-800-589-7337	AdminaStar Federal Inc. 1-800-270-2313
OKLAHOMA			
1-800-763-2828 405-521-6628	Aetna Life Insurance Company 1-800-522-9079 or 405-848-7711	Oklahoma Foundation for Peer Review 1-800-522-3414 or 405-840-2891	Palmetto Government Benefits Administrators 1-800-213-5452

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OREGON			
1-800-722-4134	Aetna Life Insurance Company 1-800-452-0125 or 503-222-6831	Oregon Medical Professional Review Org. 1-800-344-4354 or 503-279-0100	CIGNA Medicare 1-800-899-7095
PENNSYLVANIA			
1-800-783-7067	Xact Medicare Services 1-800-382-1274	Keystone Peer Review Organization, Inc. 1-800-322-1914 or 717-564-8288	MetraHealth 1-800-842-2052
RHODE ISLAND			
1-800-322-2880	Blue Cross / Blue Shield of RI 1-800-662-5170 or 401-861-2273	Health Care Review, Inc. 1-800-662-5028 * 401-331-6661	MetraHealth 1-800-842-2052
SOUTH CAROLINA			
1-800-868-9095 803-737-7500	Palmetto Govt Benefits Administrators 1-800-868-2522 or 803-788-3882	Carolina Medical Review 1-800-922-5089 or 803-731-8225	Palmetto Government Benefits Administrators 1-800-213-5452
SOUTH DAKOTA			
1-800-822-8804 605-773-3656	Blue Shield of North Dakota 1-800-437-4762	South Dakota Foundation for Medical Care 1-800-658-2285	CIGNA Medicare 1-800-899-7095
TENNESSEE			
1-800-525-2816	CIGNA Medicare 1-800-342-8900 or 615-244-5650	Mid-South Foundation for Medical Care 1-800-489-4633	Palmetto Government Benefits Administrators 1-800-213-5452
TEXAS			
1-800-252-3439	Blue Cross & Blue Shield of Texas 1-800-442-2620 or 214-235-3433	Texas Medical Foundation 1-800-725-8315 or 512-329-6610	Palmetto Government Benefits Administrators 1-800-213-5452
UTAH			
1-800-439-3805 801-538-3910	Blue Shield of Utah 1-800-426-3477 or 801-481-6196	HealthInsight 1-800-274-2290	CIGNA Medicare 1-800-899-7095
VERMONT			
802-828-3302	C and S Administrative Services 1-800-447-1142 or 207-828-4300	Northeast Health Care Quality Foundation 1-800-772-0151 or 603-749-1641	MetraHealth 1-800-842-2052

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VIRGINIA			
1-800-552-3402	Xact Medicare Services Counties of: Arlington, Fairfax 1-800-233-1124 Rest of State: MetraHealth 1-800-552-3423 or 804-330-4786	Medical Society of Virginia Review Organization DC, MD, VA 1-800-545-3814 or 804-289-5320 Richmond 804-289-5397	AdminaStar Federal Inc. 1-800-270-2313
WASHINGTON			
1-800-397-4422	Aetna Life Insurance Company 1-800-372-6604 or 206-621-0359	PRO-WEST 1-800-445-6941 or 206-368-8272	CIGNA Medicare 1-800-899-7095
WEST VIRGINA			
1-800-642-9004 304-558-3317	Nationwide Mutual Insurance Co. 1-800-848-0106 or 614-249-7157	West Virginia Medical Institute, Inc. 1-800-642-8686, ext. 266 Charleston 346-9864	AdminaStar Federal Inc. 1-800-270-2313
WISCONSIN			
1-800-242-1060	WPS 1-800-944-0051 or 608-221-3330 TDD 1-800-828-2837	Wisconsin Peer Review Organization 1-800-362-2320 or 608-274-1940	AdminaStar Federal Inc. 1-800-270-2313
WYOMING			
1-800-856-4398	Blue Cross & Blue Shield of N.D. 1-800-442-2371 or 307-632-9381	Mont/Wyo Foundation for Medical Care 1-800-497—8232 or *406-443-4020	CIGNA Medicare 1-800-899-7095
AMERICAN SAMOA			
None	Hawaii Medical Service Association 808-944-2247	Hawaii Medical Service Association/HMSA *808-948-5110	CIGNA Medicare 1-800-899-7095
GUAM			
671-475-0262/3	Aetna Life Insurance Company 808-524-1240	Hawaii Medical Service Association/HMSA *808-948-5110	CIGNA Medicare 1-800-899-7095
NORTHERN MARIANA ISLANDS			
NONE	Aetna Life Insurance Company 808-524-1240	Hawaii Medical Service Association/HMSA *808-948-5110	CIGNA Medicare 1-800-899-7095

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PUERTO RICO			
809-721-8590	Triple-S, Inc. 1-800-981-7015 in Puerto Rico 809-749-4900 Metro area	Puerto Rico Foundation for Medical Care *809-753-6705 or *809-753-6708	Palmetto Government Benefits Administrators 1-800-213-5452
VIRGIN ISLANDS			
809-774-2991	Triple S, Inc. St. Thomas 809-774-7915 St. Croix 809-773-9548	Virgin Islands Medical Institute *809-778-6470	Palmetto Government Benefits Administrators 1-800-213-5452

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Health Care Financing Administration Regional Offices

Customer Services	Regional Office	States Served
617-565-1232	Boston	CT, ME, MA, NH, RI, VT
212-264-3657	New York	NY, NJ, PR, VI
215-596-1335	Philadelphia	DE, DC, MD, PA, VA, WV
404-331-2044	Atlanta	AL, FL, GA, KY, MS, NC, SC, TN
312-353-7180	Chicago	IL, IN, MI, MN, OH, WI
214-767-6401	Dallas	AR, LA, NM, OK, TX
816-426-2866	Kansas City	IA, KS, MO, NE
303-844-4024	Denver	CO, MT, ND, SD, UT, WY
415-744-3602	San Francisco	AZ, CA, GU, HI, NV
206-615-2354	Seattle	AK, ID, OR, WA

TTY For the Hearing and Speech Impaired: 1-800-820-1202

GLOSSARY

Approved Amount: The amount Medicare determines to be reasonable for a service that is covered under Part B. It may be less than the actual amount charged. For many services, including doctor services, the approved amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

Assignment: An arrangement whereby a doctor or medical equipment supplier agrees to accept the Medicare-approved amount as full payment for services and supplies covered under Part B. Medicare usually pays 80 percent of the approved amount directly to the doctor or supplier after the beneficiary meets the annual Part B deductible of $100. The beneficiary pays the other 20 percent.

Benefit Period: A benefit period is a way of measuring a beneficiary's use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day the beneficiary is hospitalized. It ends after the beneficiary has been out of the hospital or other facility that primarily provides skilled nursing or rehabilitation services for 60 days in a row. If the beneficiary is hospitalized after 60 days, a new benefit period begins, most Part A benefits are renewed, and the beneficiary must pay a new inpatient hospital deductible. Benefit periods are unlimited.

Coinsurance: The portion or percentage of the Medicare-approved amount that a beneficiary is responsible for paying.

Deductible: The amount of expense a beneficiary must pay before Medicare begins payment for covered services.

Excess Charge: The difference between the Medicare-approved amount for a service or supply and the actual charge, if the actual charge is more than the approved amount.

Limiting Charge: The maximum amount a doctor may charge a Medicare beneficiary for a covered service if the doctor does not accept assignment of the Medicare claim. The limit is 15 percent above Medicare's approved amount for a particular service. Limiting charge information appears on the *Explanation of Medicare Benefits (EOMB)* form sent beneficiaries after they receive services covered by Part B.

Medicaid: A federally aided, state operated program that provides medical benefits for certain low-income persons.

Medicare Hospital Insurance: This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.

Medicare Medical Insurance: This is Part B of Medicare. It helps pay for medically necessary doctor services and many other medical services and supplies.

Medigap Insurance: These policies are sold by private insurance companies. They are specifically designed to help pay health care expenses either not covered or not fully covered by Medicare.

Participating Doctor or Supplier: A doctor or medical supplier who agrees to accept assignment on all Medicare claims.

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